

Step-by-Step Instructions for Completing The CMS/HCFA 1500 Claim Form For MaineCare Covered Services

Introduction

The CMS 1500 form, previously known as the HCFA 1500 form, is a billing form maintained by the National Uniform Billing Committee (NUBC). Each payer, including MaineCare, has different requirements for completing specific parts of the claim form.

You are responsible for obtaining your own CMS/HCFA 1500 forms; the Maine Department of Health and Human Services (DHHS) does not provide them.

CMS/HCFA 1500 forms are red printing on white paper. You can buy the forms at office supply centers and from other sources including:

U.S. Government Printing Office
Mail Stop: IDCC
732 N. Capitol St. NW
Washington, DC 20401
<http://www.gpo.gov/>

Cover the Bar Code

DHHS stamps your claim's unique Transaction Control Number (TCN) at the upper left-hand corner of the claim. Because of this, if you purchase a CMS/HCFA 1500 form that has a bar code in the upper left-hand corner, you need to cover the bar code before submitting the form. We recommend a white sticker to cover the bar code.

Who Must Use the CMS/HCFA 1500

If you are one of the following providers, you must use the CMS/HCFA 1500 form:

Advance Practice Registered Nursing Services
Ambulances
Ambulatory Care Clinics
Ambulatory Surgical Centers

Audiologists
Chiropractic Services
Community Support Services
Consumer Directed Attendant Services
Day Habilitation Services for Persons with Mental Retardation
Day Health Services
Day Treatment Services
Developmental and Behavioral Clinics
Medical Supplies and Durable Medical Equipment
Early Intervention Services
Family Planning Clinics
Federally Qualified Health Centers
Genetic Testing and Clinical Genetic Services
Hearing Aids and Services
Home and Community Based Benefits for the Elderly and
for Adults with Disabilities
Home and Community Based Benefits for Members
with Mental Retardation
Home and Community Based Benefits for the Physically Disabled
Home Based Mental Health Services
Independent Laboratories
Licensed Clinical Social Workers, Licensed Clinical Professional
Counselors, and Licensed Marriage and Family Therapist Services
Medical Imaging Services
Occupational Therapy Services
Optometrists
Outpatient Mental Health Providers
Physical Therapy Services
Physician Services
Psychological Services

Podiatrist Services
Rehabilitation Services
Rural Health Clinic Services
School Based Rehabilitation Services
Speech and Hearing Services
Substance Abuse Treatment Services
Targeted Case Management Providers
Transportation/Wheelchair Van Services
VD Clinics
Vision Services

You May Need Special Instructions

Some providers who use the CMS/HCFA 1500 form need to follow special instructions for certain fields. If you are one of the providers listed below, look for *Special Instructions*: and the appropriate icon for you:


MH Mental Health Providers

QMB For a member who has Qualified Medicare Beneficiary (QMB) eligibility [note: MaineCare pays the cost of Medicare premiums, deductibles and coinsurances]

SA Substance Abuse Service Providers

TRANS/AMB Full Service Transportation/Wheelchair Van and Ambulance Providers

Also look for these icons:

 **Attach** reminds you where you need to attach documentation for this claim.

➔ **Appendix** reminds you to check the Appendices for information such as billing for Medicare or other insurance.

Appendix A is on Page 40; Appendix B is on Page 43;
and Appendix C is on Page 44.

Required and Not Required Boxes and Fields

Boxes and fields that are not required are shaded. All required boxes are clear.

Not Required:

Box 1:						
1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
<input type="text"/> (Medicare #)	<input type="text"/> (Medicaid #)	<input type="text"/> (Sponsor's SSN)	<input type="text"/> (VA File #)	<input type="text"/> (SSN or ID)	<input type="text"/> (SSN)	<input type="text"/> (ID)

Not required.

Required:

Box 28: TOTAL CHARGE	
28. TOTAL CHARGE	
\$	

Total the charges in Box 24, Column F, and enter that amount here.

Example:

28. TOTAL CHARGE	
\$	1102 00

Please note, although some boxes are not required, they are not shaded. This is because DHHS recommends that you enter optional information in these boxes. This optional information, such as the patient's account number, will help you in your recordkeeping.

Examples and Additional Help

The instructions for each required box or field include an example of what the completed box or field should look like. In some boxes that have special instructions for certain providers, there are additional examples for those providers.

The instructions also give you important information and help.

Look for these icons:



ALERT: Required Action



TIP: Helpful Hint

Additional Tips on Filing

Here's other important information you need to know before you begin filling out your form:

- Use current CPT (Current Procedural Terminology) of the American Medical Association, ICD 9 (International Classification of Diseases) Diagnostic Codes, or HCPCS (Healthcare Common Procedure Coding System) Codes maintained by the Centers for Medicare and Medicaid Services. Or,
- Use the Procedure Codes in Chapter III of the *MaineCare Benefits Manual* policy section under which you bill. You may access these codes at the following website: <http://www.maine.gov/sos/cec/rules/10/ch101.htm>
- The required format for a birth date is MMDDYYYY. (Example: January 19, 1947 = 01191947.)
- Whether you fill in your claim form by typing, computer, or handwriting, keep all information within the designated boxes. Do not overlap information into other fields. If the information is not in the required fields your claims will be returned to you with a cover letter stating that the information is not aligned correctly.

Mailing Your Claim

If you are a Transportation provider, mail your completed claim form to this address:

MaineCare Claims Processing
M-1400
Augusta, ME 04333

All other providers, mail your completed claim form to this address:

MaineCare Claims Processing
M-500
Augusta, ME 04333

You may also bill electronically through Electronic Media Claims (EMC) batch billing. Contact the Provider File Unit at 1-800-321-5557, Option 6 (In State only) or 207-287-4082 for more information on electronic billing. You can find additional information on the website for the Office of MaineCare Services (OMS) at: <http://www.maine.gov/dhhs/emc/index.htm>

The following are the step-by-step instructions for completing each box or field in the CMS/HCFA 1500 form.

Instructions for All Boxes and Fields on The CMS/HCFA 1500 Claim Form

**Boxes
1, 1a**

Box 1:

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
<input type="checkbox"/> (Medicare #)	<input type="checkbox"/> (Medicaid #)	<input type="checkbox"/> (Sponsor's SSN)	<input type="checkbox"/> (VA File #)	<input type="checkbox"/> (SSN or ID)	<input type="checkbox"/> (SSN)	<input type="checkbox"/> (ID)

Not required.


Box 1a: INSURED'S I.D. NUMBER

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

Enter the member's MaineCare ID number exactly as shown on the member's MaineCare ID card.

Example:

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
12121212A

 TIP:

You must verify the member's eligibility status. Use the swipe card system or the Interactive Voice Response (IVR) system at 1-800-452-4694 (In State Only) or 207-287-3081 (In State or Out of State).

BOX 2: PATIENT'S NAME

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Enter the member's last name, first name and middle initial (if any) **exactly** as shown on his/her MaineCare ID card.

*Example: Member's name is Belle St. Pierre, the MaineCare Card reads St Pierre, Belle with no punctuation, **replace the period with a space as shown on the MaineCare Card.***

Example:

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

St Pierre, Belle



ALERT:

Enter the member's name **exactly** as shown on the MaineCare ID card. If the name does not match, the claim will deny for incorrect name.

BOX 3: PATIENT'S BIRTH DATE AND SEX

3. PATIENT'S BIRTH DATE
MM DD YY M ☐ F ☐

Enter the month, day and year the member was born. The format for a birth date must be MMDDYYYY.

Enter an X in the appropriate M or F checkbox for the member's sex.

Example:

3. PATIENT'S BIRTH DATE
MM DD YY M ☐ F ☒

06 21 1951

M

☐

F

☒



TIP:

Throughout this form, please enter information within the boundaries of each box or field. Do not overlap into other boxes or fields.

Box 4: INSURED'S NAME

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

Not required.

Box 5: PATIENT'S ADDRESS

5. PATIENT'S ADDRESS (No., Street)

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code)

()

Not required.

Box 6: PATIENT RELATIONSHIP TO INSURED

6. PATIENT RELATIONSHIP TO INSURED

Self ☐

Spouse ☐

Child ☐

Other ☐

Not required.

Box 7: INSURED'S ADDRESS

7. INSURED'S ADDRESS (No., Street)

CITY

STATE

ZIP CODE

TELEPHONE (INCLUDE AREA CODE)

()

Not required.

Box 8: PATIENT STATUS

8. PATIENT STATUS

Single ☐

Married ☐

Other ☐

Employed ☐

Full-Time Student ☐

Part-Time Student ☐

Not required.

Box 9: OTHER INSURED'S NAME

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			
b. OTHER INSURED'S DATE OF BIRTH		SEX	
MM	DD	YY	M <input type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME			

If the member is covered by a primary insurance other than MaineCare or Medicare, enter the name of the policyholder. Do not enter Medicare or any other State program information. If you complete this box, also complete Boxes 9a and 9d. Instructions for Boxes 9a and 9d are on the next page.

If there is no other insurance, leave this box and all fields (9–9d) blank.

Example:

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
Smith, John M.			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			
111-11-1111			
b. OTHER INSURED'S DATE OF BIRTH		SEX	
MM	DD	YY	M <input checked="" type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME			
Anthem Blue Cross Plan B			



ALERT:

You must submit the claim to other insurers prior to submitting the claim to MaineCare.



Attach a copy of the Explanation of Benefits or Remittance Statement from the primary insurance.

Box 9a: OTHER INSURED'S POLICY OR GROUP NUMBER

Enter the policy or group number of the primary insurance.

Box 9d: INSURANCE PLAN NAME OR PROGRAM NAME

Enter the name of the primary insurance plan or program name. (Example: Anthem Blue Cross Plan B.)

Do not enter Medicare or MaineCare in this field.

Example:

g. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
Smith, John M.			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			
111-11-1111			
b. OTHER INSURED'S DATE OF BIRTH			SEX
MM	DD	YY	M <input type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME			
Anthem Blue Cross Plan B			
d. INSURANCE PLAN NAME OR PROGRAM NAME			



ALERT:

You must submit the claim to other insurers prior to submitting the claim to MaineCare.

Box 10: IS PATIENT'S CONDITION RELATED TO:

10. IS PATIENT'S CONDITION RELATED TO:		
a. EMPLOYMENT? (CURRENT OR PREVIOUS)		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	
b. AUTO ACCIDENT?	PLACE (State)	
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="text"/>
c. OTHER ACCIDENT?		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	

If applicable, enter an X in each appropriate checkbox (a, b, and c). If a, b, and c are not applicable, you may leave those checkboxes blank.

Box 10a: EMPLOYMENT? (CURRENT OR PREVIOUS)

Box 10b: AUTO ACCIDENT? / PLACE (STATE)

Box 10c: OTHER ACCIDENT

Example:

10. IS PATIENT'S CONDITION RELATED TO:		
a. EMPLOYMENT? (CURRENT OR PREVIOUS)		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	X
b. AUTO ACCIDENT?	PLACE (State)	
<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	PA
c. OTHER ACCIDENT?		
<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	

Box 10d: RESERVED FOR LOCAL USE

10d. RESERVED FOR LOCAL USE

Not Required

Example:

10d. RESERVED FOR LOCAL USE

Box 11: INSURED'S POLICY GROUP OR FECA NUMBER

11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. INSURED'S DATE OF BIRTH		SEX	
MM	DD	YY	M <input type="checkbox"/> F <input type="checkbox"/>
b. EMPLOYER'S NAME OR SCHOOL NAME			
c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			

If YES is checked in Box 11d, enter the policy or group number.
Do not enter Medicare or any State program.

Box 11a: INSURED'S DATE OF BIRTH AND SEX

If YES is checked in Box 11d, enter the month, day and year the policyholder was born. The format for a birth date must be MMDDYYYY.

Enter an X in the appropriate box for the policyholder's sex.

Box 11b: EMPLOYER'S NAME OR SCHOOL NAME

If YES is checked in Box 11d, enter the name of the policyholder's employer or school.

Box 11c: INSURANCE PLAN NAME OR PROGRAM NAME

If YES is checked in Box 11d, enter the name of the policyholder's insurance plan or program. Do not enter Medicare or the name of any State program.

Box 11d: IS THERE ANOTHER HEALTH BENEFIT PLAN?

If the MaineCare member is covered by other primary insurance and he/she is not the policyholder, enter an X in the YES box and also complete Fields 9a–9c. Do not check the YES box if the member has Medicare or is covered by any other State program. If there is no other insurance, enter an X in the NO box.

Example:

11. INSURED'S POLICY GROUP OR FECA NUMBER			
41216			
a. INSURED'S DATE OF BIRTH		SEX	
MM	DD	YY	M <input checked="" type="checkbox"/> F <input type="checkbox"/>
06	16	1947	
b. EMPLOYER'S NAME OR SCHOOL NAME			
Acme Corporation			
c. INSURANCE PLAN NAME OR PROGRAM NAME			
Anthem Blue Cross Plan B			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			

**Boxes
11 – 11d****ALERT:**

If the member has a secondary insurance other than MaineCare or Medicare this block must be completed.

Box 12: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

Not required.

Box 13: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

Not required.

Box 14: DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

Not required.

Box 15: IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE

Not required.

Box 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

Not required.

**Boxes
17, 17a**

Box 17: NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

Not required.

Box 17a: I.D. NUMBER OF REFERRING PHYSICIAN

17a. I.D. NUMBER OF REFERRING PHYSICIAN

If the member is enrolled in MaineCare Managed Care and the service requires a referral number from the Primary Care Provider (PCP) site, enter the PCP's site-specific, nine-digit referral number.

Example:

17a. I.D. NUMBER OF REFERRING PHYSICIAN
000203000

For additional information regarding MaineCare Managed Care, please use the following website:

http://www.maine.gov/dhhs/bms/providerfiles/provider_managed_care.htm



ALERT:

Enter the MaineCare Managed Care Referral Number only. All Managed Care referral numbers begin with 000.

Box 18: HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
FROM	MM	DD	YY	TO	MM	DD	YY

Not required.

Box 19: RESERVED FOR LOCAL USE

19. RESERVED FOR LOCAL USE

If you are billing a J code in Box 24D, enter the National Drug Code (NDC) for that drug. Do not enter the description of the drug, and do not enter NDC before the actual NDC code.

Only one J code may be billed per claim.

Example:

19. RESERVED FOR LOCAL USE
0005264222



ALERT:

You can only bill one J code on a paper claim. If you try to bill an NDC code electronically, the system won't read the code.

If there is an appropriate J code you must use it instead of a 9000 code.

Box 20: OUTSIDE LAB?

20. OUTSIDE LAB?		\$ CHARGES
<input type="checkbox"/> YES	<input type="checkbox"/> NO	

Not required.

Box 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	
1. _____	3. _____
2. _____	4. _____

On the line after 1., enter the numeric International Classification of Diseases (ICD-9) code only. Use the code that is as specific as possible, according to ICD-9 coding guidelines. Do not enter the description of the diagnostic code.

If there is more than one diagnosis, enter each code on the line after 2., 3., and 4. You may not enter more than four diagnoses.

Example:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)	
1. <u>3182</u>	3. _____
2. <u>31532</u>	4. _____

Special Instructions:

TRANS Full Service Transportation/Wheelchair Van Providers only: Not required.



ALERT:

As a Provider, you are expected to have up-to-date code books for diagnoses and procedure codes.

Do not use a decimal point in the diagnosis code.

Box 22: MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
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Note: This box is now required. It replaces the pink and green adjustment forms.

If this is an adjustment claim, in the Medicaid Resubmission Code field, enter one of the following:

7 – for **Replacement** of a previous claim

8 – for **Void** or **Cancel**

In the Original Ref. No. field, enter the previous Transaction Control Number (TCN) for the line you are adjusting.

 **Attach** a copy of your original claim and remittance advice statement (RA) that shows the corresponding TCN.

Example: 7

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7	002005045520029000

**Boxes
22-23****ALERT:**

To replace or void the entire claim enter the Original Ref. No. (TCN) that ends with zero.

If you do not replace or void the entire claim you can only replace one line per claim using the line TCN ending in 01, 02, 03, etc.

Do not do adjustments at this time. The functionality is not yet available. Providers will be notified when it is.

Box 23: PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER

If applicable, enter the nine-digit Prior Authorization number issued by the authorizing unit for the services or supplies being billed on this form. You may bill only one Prior Authorization number on each claim form.

All provider except LCSW's, LCPC's, or LMFT's refer to Chapter 1 or the applicable policy of the *MaineCare Benefits Manual*.

Example:

23. PRIOR AUTHORIZATION NUMBER
100112333

**ALERT:**

If you are a LCSW, LCPC, or LMFT billing under Chapter II, Section 58 of the *MaineCare Benefits Manual*, all services require a Prior Authorization number.

Box 24: (BOX HAS NO TITLE)

- ➔ Appendix A: If you are allowed to bill for Medicare coinsurance and deductible (**you are a Provider listed in Box 24J**), see **Appendix A, Page 40**, for billing coinsurance and deductible.
- ➔ Appendix B: If you are billing after Medicare and you **are not a Provider listed in Box 24J**, see **Appendix B, Page 43**.
- ➔ Appendix C: If you are **billing after commercial insurance**, see **Appendix C, Page 44**.

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER													
1																	
2																	
3																	
4																	
5																	
6																	

For each line item billed, you must include one date, one place of service, one procedure code, and one amount charged per line. For a paper claim, you may not bill more than six lines.

See the following pages for instructions for Boxes 24A–24K.



ALERT:
Appendix A providers are required to put a **Y** indicator in **Box 24J**.



ALERT:
This claim is limited to six lines.

Box 24A: DATE(S) OF SERVICE

Enter both “From” and “To” dates of service using eight-digit format is MMDDYYYY. Do not use commas, dashes, or slashes in the date.

Dates must be consecutive and continuous. If the service was provided on only one day, just put that date in the From field. On each line, the From and To dates must be during one month. Use the next line for the next month.

Example:

24. A					
DATE(S) OF SERVICE					
From			To		
MM	DD	YY	MM	DD	YY
02	15	2006	02	16	2006
03	29	2006	03	31	2006
04	01	2006	04	03	2006



ALERT:

You can call
1-800-321-5557 to
check the member's
eligibility.

Box 24B: PLACE OF SERVICE

Enter a two-digit Place of Service code from the following list:

- 01 Pharmacy
- 03 School
- 04 Homeless Shelter
- 05 Indian Health Service Free-standing Facility
- 06 Indian Health Service Provider-based Facility
- 07 Tribal 638 Free-standing Facility
- 08 Tribal 638 Provider Based Facility
- 11 Office
- 12 Home
- 13 Assisted Living Facility
- 14 Group Home
- 15 Mobile Unit
- 20 Urgent Care Facility
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room – Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance – Land
- 42 Ambulance – Air or Water
- 49 Independent Clinic

(Code list continued on the next page.)



ALERT:

**Early
Intervention
Programs:**

Use Place of Service **code 99**.

**Full Service
Transportation/
Wheelchair Van
Providers:**

Use the Place of Service code you transported the member to.

**Durable
Medical
Equipment
and Supplies
Providers:**

Use the Place of Service code where the member resides.

Medical Imaging
Mobile Unit use
Place of Service
Code 15.

(Place of Service codes continued)

- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility – Partial Hospitalization
- 53 Community Mental Health Center
- 54 ICF/MR
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Facility
- 57 Non-Resident Substance Abuse Treatment Facility
- 61 Comprehensive Inpatient Rehabilitation Center
- 62 Comprehensive Outpatient Rehabilitation Center
- 65 End Stage Renal Disease Treatment Facility
- 71 State or Local Public Health Clinic
- 72 Rural Health Center
- 81 Independent Laboratory
- 99 Other

Example:

B
Place of Service
53

**Box
24C**

Box 24C: TYPE OF SERVICE

C Type of Service

Not required.

Box 24D

Box 24D: PROCEDURES, SERVICES OR SUPPLIES

Enter the appropriate procedure code and modifier(s), if necessary. Procedure codes and modifiers are in Chapter III of the *MaineCare Benefits Manual* and on the Office of MaineCare Services website, <http://www.state.me.us/bms/bmshome.htm>

Transportation Example:

D		
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		
CPT/HCPCS	MODIFIER	
T042	ED	

Physician Example:

D		
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		
CPT/HCPCS	MODIFIER	
38760	80	50

Ambulance Example:

D		
PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		
CPT/HCPCS	MODIFIER	
A0428	H9	PH

(Instructions for 24D continued on the next page.)



ALERT:

CRNAS
(Certified
Registered
Nurse
Anesthetist)
billing for
anesthesia
must use the
QZ modifier.

ASCS
(Ambulatory
Surgical
Centers)
must use an
SG modifier
with the CPT
code.



TIP:

Be sure that
all
information
is legible and
in the proper
block.

(24D continued.)

TRANS/AMB Full Service Transportation/Wheelchair Van and Ambulance Providers:

In the Modifier field, enter the appropriate two letters for the transport's place of origin and destination from the following list (as shown in the example above):

- D. Diagnostic or therapeutic site other than P or H.
- E. Residential domiciliary, custodial facility (nursing home, not skilled nursing facility)
- G. Hospital-based dialysis facility (hospital or hospital-related)
- H. Hospital
- I. Site transfer (e.g., airport or helicopter pad) between modes of ambulance transport
- J. Non-hospital-based dialysis facility
- N. Skilled nursing facility (SNF)
- P. Physician's office (includes HMO non-hospital facility, clinic, etc.)
- R. Residence
- S. Scene of accident or acute event
- X. (Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMP non-hospital facility, clinic, etc.)
- QL. Patient pronounced dead after ambulance called
- UC. Unclassified ambulance service

Use of Modifier U1: Please see instructions for Box 24K.

Box 24E: DIAGNOSIS CODE

From Box 21, enter the line number or numbers (1, 2, 3, and/or 4) that list the diagnosis codes. Do not enter the codes themselves. List only the line numbers.

Example:

E
DIAGNOSIS CODE
1
1,3
2,3
1,2,3
2,4
1,2,3,4

Special Instructions:

TRANS Full Service Transportation/Wheelchair Van Providers only: Not required.

Box 24F: \$ CHARGES

Enter the charge for the service you provided based on the policy section under which you are billing.

For more information on charges, see the MaineCare Benefits Manual (<http://www.maine.gov/sos/cec/rules/10/ch101.htm>).

- ➔ Appendix A: If you are allowed to bill for Medicare coinsurance and deductible (you are a Provider listed in Box 24J), see Appendix A, Page 40.


QMB If a member has Qualified Medicare Beneficiary (QMB) eligibility only and Medicare has approved the service, follow the instructions in Appendix A for billing Medicare coinsurance and deductible. If Medicare has not approved the service, no reimbursement is available.

- ➔ Appendix B: If you are not listed in Box 24J and you are billing after Medicare, see Appendix B, Page 42.
- ➔ Appendix C: If you are billing after commercial insurance, see Appendix C, Page 43.

If you are submitting for services that have been prior authorized, you must enter the lower of your usual and customary charges, or enter the prior authorized amount.

Example:

F	
\$ CHARGES	
55	00

 TIP:

Do not put a \$ sign before the total. The \$ can be picked up as an 8.

 TIP:

You should bill the total charges for all units in 24 G.

Box 24G: DAYS OR UNITS

Enter the number of days of service or the units of supplies provided. Do not use decimal points or fractions. Round off to the nearest whole number. Enter 1 only if 1 unit was provided. (For example: For Indian Health Centers or Rural Health Centers, 1 unit of a visit is 1, not the units of itemized services provided in that visit.)

To find the definition of a unit, refer to the code descriptions or maximum allowance column in Chapter III of the *MaineCare Benefits Manual*, or refer to the CPT and HCPCS standard code listings.

Example:

G DAYS OR UNITS
1



ALERT:

Do not leave this field blank. Units must be whole numbers **do not** use $\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$, etc.

Box 24H: EPSDT FAMILY PLAN	
H	
EPSDT	
Family	
Plan	

Not required.

Box 24I: EMG	
I	
EMG	
Y	

Enter a Y to prevent copay from being deducted if you are not billing services that are exempt from copay.

Refer to Chapter I of the *MaineCare Benefits Manual* for a list of services exempt from copays.

Example:



TIP:

This box replaces the EMR diagnosis code previously used to bypass copay according to Chapter I.

24J: COB

Enter a **Y** when billing for Medicare coinsurance or deductible if you are one of the following:

Ambulance
Ambulatory Care Clinic
Indian Health Center
Advanced Nurse Practitioner
Mental Health Clinic
Optometrist
Physician
Podiatrist
Psychologist
QMB/“Quimby” Provider
(See Special Instructions below)
Federally Qualified Health Center
Rural Health Center

Example:

J
COB
Y

Special Instructions:

QMB If the member has QMB eligibility only and Medicare has approved the service, enter a Y. See Appendix A, Page 40, for billing Medicare coinsurance and deductible.

**Box
24J**



ALERT:

You must put a Y in this box if you are one of the providers listed.



TIP:

Ambulatory Surgical Centers are not the same as an Ambulatory Care Clinic.

24K: RESERVED FOR LOCAL USE

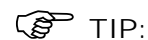
Enter the Servicing Provider ID number, if applicable.

If a Servicing Provider ID number is not required, leave this field empty.

Example:

K
RESERVED FOR LOCAL USE
333333399

See Special Instructions for Box 24K on the next page, including a list of provider types that are not required to enter a Servicing Provider ID number.



TIP:

Refer to your MaineCare enrollment letter for your Servicing Provider ID number or numbers.



ALERT:

The **Servicing Provider ID** number **always ends in 99**.

Special Instructions for Box 24K

If you are one of the following providers or services, a Servicing Provider ID number is not required in Field 24K:

Ambulance

Ambulatory Surgical Center

BMR Waiver Provider – Section 21

Case Management Provider – Section 17

Community Support Services

CBB10

CBB17

Consumer Directed Attendant Service – Section 12

Day Habilitation Provider – Free Standing Day Habilitation
billing under Section 24

Day Health – Section 26

Day Treatment Services Provider

Developmental/Behavioral Clinic Provider – Section 23

Durable Medical Equipment and Supplies Provider

Early Intervention Program

Full Service Transportation/Wheelchair Van Services

Genetic Testing and Clinical Genetic Services – Section 62

Home Based Mental Health Provider – Section 37

Laboratory Services – Section 55

Medical Imaging – Section 101

(List continued on the next page.)



TIP:

Refer to your
MaineCare
enrollment letter
for your
Servicing Provider
ID number or
numbers.



ALERT:

The **Servicing
Provider ID**
number **always
ends in 99.**

If a Servicing
Provider ID
number is not
required, leave
this field empty.

(Special Instructions for Box 24K, continued.)

(Provider types that are not required to enter a Servicing Provider ID number in Box 24K.)

Mental Health Agency

Children's Service Codes (For the following procedure codes, 24K must be left blank):

Z4107 Day Treatment

Z4186 Child Crisis Support (per diem unit)

Z4187 Child Family & Community Support
(per diem unit)

ZNC11 Family Psychoeducation

ZNC16 Child ACT

Adult Service Codes (For the following procedure codes, 24K must be left blank):

Z4169 Adult Crisis Support (per diem unit)

Z4188 Psychoeducation

Optical Contractor

Rehabilitation Services Provider – Section 102

School Based Rehabilitation Provider

Substance Abuse Service Provider (For the following procedure codes, 24K must be left blank):

H0015 Intensive Outpatient Services

H0020 Methadone Clinic Services

VD Screening Clinic Services – Section 150

Using Modifier U1 for services provided by “Other Qualified Staff”: In Field 24D, if services were provided by “Other Qualified Staff,” you must fill in the appropriate procedure code with the Modifier U1. You must then enter the Servicing ID number of the licensed clinical supervisor here (Field 24K).



ALERT:

The **Servicing Provider ID** number always **ends in 99**.



TIP:

If you have questions call 1-800-321-5557 or 207-287-3081.



ALERT:

Please note these instructions for Modifier U1.

**Box
25**

Box 25: FEDERAL TAX I.D. NUMBER


25. FEDERAL TAX I.D. NUMBER	SSN EIN
	<input type="checkbox"/> <input type="checkbox"/>

Although this is not required, DHHS highly recommends that you enter this information. If the Provider ID number in Box 33 is incorrect or missing, the claims unit uses the information in this box to inform you that your claim is denied.

The SSN and EIN checkboxes are not required.

Example:

25. FEDERAL TAX I.D. NUMBER	SSN EIN
000000000	<input type="checkbox"/> <input type="checkbox"/>

 TIP:

This is not your
MaineCare
Provider
Number.

Box 26: PATIENT'S ACCOUNT NO.

26. PATIENT'S ACCOUNT NO.

Although this box is not required, DHHS highly recommends including the patient's account number or the member's name here. If the MaineCare member's ID number in Box 1A is incorrect, the information you enter in this box will appear on your remittance statement. You will then be able to cross-reference the RA and your records.

If you are using a patient account number, enter the number (any alphanumeric combination up to 12 characters). If you do not use a patient account number, enter the member's name.

Example:

26. PATIENT'S ACCOUNT NO.

12345

Or:

26. PATIENT'S ACCOUNT NO.

SmithJ1

Box 27: ACCEPT ASSIGNMENT?27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)☐

YES

☐

NO

Not required.

**Box
28**

Box 28: TOTAL CHARGE

28. TOTAL CHARGE
\$

Total the charges in Box 24, Column F, and enter that amount here.

Example:

28. TOTAL CHARGE
\$ 1102 00




ALERT:

Each claim must be totaled. **Do not** write “continued on next page.”

Box 29: AMOUNT PAID

29. AMOUNT PAID	
\$	

➔ Appendix: See Appendices A, B, and C, Pages 40–43, for billing after Medicare or other commercial insurances.

 **Attach** the third party Explanation of Benefits (EOB) for all claims involving a third party when balance billing MaineCare after you have received payment or denial from the primary health plan.

- If payment was made, you must enter the amount of the insurance payment in Box 29, as well as attach the third party Explanation of Benefits (EOB).
- In order for the claims payment system to properly distribute third party payments, only those line items paid by the third party can be billed on the same claim form.
- Those charges that have been denied by the insurer, where no third party payment was made, must be billed on a separate claim form, and you must include the third party Explanation of Benefits (EOB).
- Do not enter the Medicare payment in Box 29 if you are billing for Medicare coinsurance or deductible.

Spenddowns: Enter the total amount of payments from third party payers. If you have been issued a spenddown letter from the Office of Integrated Access and Support, enter the **patient responsibility** amount. The dates and amounts on this claim must match the spenddown letter.

 **Attach** the spenddown letter to this claim.

Example:

29. AMOUNT PAID	
\$	456 00

 TIP:

Do not enter the member's anticipated copay amount. It will be automatically deducted in the claims process.

 ALERT:

Be sure to attach a copy of the spenddown letter to each page of the claim.

Box 30: BALANCE DUE

30. BALANCE DUE	
\$	

Enter the balance due. Subtract the amount in Box 29 from the amount in Box 28. If Box 29 is greater than Box 28, enter 0. Do not enter negative numbers.

Example:

30. BALANCE DUE	
\$	1102 00

Box 31: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
SIGNED	DATE

Enter the Provider's name and billing date. The signature or name may be typed or stamped. The Provider's authorized person may sign. The name must be the name of an actual person.

Do not use "signature on file."

Degree or credentials are not required.

The format for the billing date is MMDDYYYY.

Example:

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
John M. Doe	04072006
SIGNED	DATE



ALERT:

The signed date must be the same date or a date later than the last date of service on this form.

Services may not be billed before they are provided.

Box 32: NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

If services were in a location other than the Provider's office or the member's home, enter the name and address of that facility.

Example:

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Midtown Hospital
345 South Main St.
Anytown, ME 04000

**Box 33: PHYSICIAN'S, SUPPLIER'S BILLING NAME,
ADDRESS, ZIP CODE & PHONE #**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
PIN#	GRP#

Enter the Provider's name, address, and nine-digit Billing Provider ID number. Be sure to enter the Provider ID number in the field directly to the right of PIN#. Do not enter the Servicing Provider ID number here.

A telephone number is not required. If you do include a phone number, please take care not to overlap the Provider ID number with the telephone number.

The GRP# is not required. Do not use GRP# for your Billing Provider ID number.

Example:

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
Family Health Services 2 County Road Anytown, ME 04000 (207) 000-0000	
PIN# 000000000	GRP#



ALERT:

The PIN# must be located beside PIN# in this box.

Do not put anything after the GRP# and do not put a phone number in the box beside GRP#.

Appendix A

Billing Medicare Coinsurance and Deductible to MaineCare

Providers who are listed to receive
coinsurance and deductible in full after Medicare

Important: You must bill any third party companion plans prior to billing
MaineCare.

**If you are one of the following Providers, you are allowed to bill for Medicare
coinsurance and deductible:**

Ambulance
Ambulatory Care Clinic
Indian Health Center
Advanced Nurse Practitioner
Mental Health Clinic
Optometrist
Physician
Podiatrist
Psychologist
QMB/“Quimby” Provider
Federally Qualified Health Center
Rural Health Center
Member has QMB eligibility only

If you are one of the above your special instructions are on the next page:

If you are an Ambulance Ambulatory Care Clinic, Advanced Nurse Practitioner, Optometrist, Physician, Podiatrist, Psychologist, QMB/“Quimby” Provider, or Member is a Qualified Medicare Beneficiary (QMB) eligibility only:

Box 21: You are required to use a diagnostic code.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Charges must reflect the sum of the Medicare coinsurance and deductible amounts as shown on the Explanation of Medicare Benefits (EOMB).

Box 24J: Enter a Y when billing for Medicare coinsurance and deductible.

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter any other third party payment from an insurance company. Do not enter the Medicare payment.

Box 30: Enter the balance due. This can not exceed the member responsibility shown on the Explanation of Benefits.

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any third party Explanation of Benefits (EOB).

If you are an Indian Health Center, a Federally Qualified Health Center, a Rural Health Center:

Box 21: You are required to use a diagnostic code.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Charges must reflect your MaineCare rate of reimbursement minus the dollar amount paid by Medicare as indicated on the Explanation of Medicare Benefits (EOMB).

Example: MaineCare rate is \$100 per visit
Medicare paid \$45 for the visit
Charges in 24F would be \$55

Box 24J: Enter a Y when billing for Medicare coinsurance and deductible.

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter any other third party payment from an insurance company. **Do not** enter the Medicare payment.

Box 30: Enter the balance due.

If you are a Mental Health Clinic or Psychologist:

Box 21: You are required to use a diagnostic code.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Charges must reflect your coinsurance and/or deductible and the amount of PR-122 as indicated on the Explanation of Medicare Benefits (EOMB).

Example: Coinsurance amount is \$20 and PR-122 is \$30
Charges in 24F would be \$50

Box 24J: Enter a Y when billing for Medicare coinsurance and deductible.

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter any other third party payment from an insurance company. **Do not** enter the Medicare payment.

Box 30: Enter the balance due.

Appendix B

Billing Medicare Coinsurance and Deductible to MaineCare

Providers who are **not** allowed to bill for coinsurance and deductible after Medicare

Important: You must bill any third party companion plans prior to billing MaineCare.

Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 21: You are required to use a diagnostic code.

Box 24D: Enter the procedure codes and modifiers normally billed to MaineCare.

Box 24F: Enter the Medicare allowed amount as shown on the Explanation of Medicare Benefits (EOMB).

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter the sum of the Medicare payment and any other third party payment from an insurance company.

Box 30: Enter the balance due. This can not exceed the member responsibility shown on the Explanation of Medicare Benefits (EOMB).

Attach a copy of the Explanation of Medicare Benefits (EOMB) and any other third party Explanation of Benefits (EOB).

Appendix C

Third Party Billing Instructions

1. Balance Billing Traditional Insurance Plans and Fee For Service Managed Care Plans
2. Physicians Billing Copays for Capitated Services Under Managed Care Plans
3. For balance billing traditional insurance plans and fee for service managed care plans

Important: You must attach the third party Explanation of Benefits to the claim form.

Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 24F: Charges must equal the allowed amount that you and the insurance company agreed to, as shown on insurance company's Explanation of Benefits (EOB).

Box 28: Enter the total charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter the amount paid by insurance company/third party. The third party amount must equal the actual third party payment, plus any withheld amount shown on the insurance company's Explanation of Benefits. You must enter this amount on the claim form, and you must attach the Explanation of Benefits.

Box 30: Enter balance due. This can not exceed the member responsibility shown on the Explanation of Benefits.

Please remember, if the third party payment exceeds the MaineCare rate for the service, there is no balance due.

Services not covered by the third party payer must be billed on a separate claim form with the Explanation of Benefits attached to the claim.

You can not charge the patient the copay.

2. For Physicians billing copays for capitated services under managed care plans:

NOTE: Capitated services are services covered under the monthly capitation payment agreement between a managed care plan and the member's provider.

Complete the CMS/HCFA 1500 claim form according to MaineCare requirements, along with the following:

Box 24D: Enter the appropriate procedure code.

Box 24F: Charges must equal the copay amount.

Box 28: Enter the total copay charges. This must equal the total of the individual line item charges in 24F.

Box 29: Enter 0 (a zero).

Box 30: Enter amount from Box 28.

Attach a copy of the Explanation of Benefits (EOB).

You can only bill copays for capitated services under a managed care plan.

Services not covered by the third party payer must be billed on a separate claim form with the Explanation of Benefits (EOB) attached to the claim.

You can not charge the patient the copay.